		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032979

Facility Name: Hitz Memorial Home

Address: 201 Belle Street (Number) Alhambra (City) 62001 (Zip Code)

County: Madison

Telephone Number: (618) 488-2355 **Fax #** (618) 488-2361

IDPA ID Number: 371222548001

Date of Initial License for Current Owners: 01/01/1968

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501c(3)		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Scheffel & Company, P.C. **Telephone Number:** (618) 656-1206

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2003 to 06/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Marcia Haslett
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Dennis E. Ulrich, Certified Public Accountant
(Firm Name & Address) Scheffel & Company, P.C., 143 North Kansas Street, Edwardsville, IL 62025
(Telephone) (618) 656-1206 Fax # (618) 656-3536

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	34	Skilled (SNF)	34	12,444	1
2		Skilled Pediatric (SNF/PED)			2
3	33	Intermediate (ICF)	33	12,078	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	67	TOTALS	67	24,522	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,570	1,570	8
9	SNF/PED					9
10	ICF	11,249	7,793		19,042	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,249	7,793	1,570	20,612	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.06%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Assisted Living

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 01/01/1968

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 9 and days of care provided 1,570

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2004 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Hitz Memorial Home # 0032979 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	139,037	7,800	5,422	152,259		152,259	(162)	152,097			1
2	Food Purchase		92,166		92,166		92,166		92,166			2
3	Housekeeping	50,225	12,775		63,000		63,000		63,000			3
4	Laundry	41,662	26,078	2,628	70,368		70,368		70,368			4
5	Heat and Other Utilities			78,638	78,638		78,638	(3,435)	75,203			5
6	Maintenance	64,371	3,427	42,215	110,013		110,013		110,013			6
7	Other (specify):*											7
8	**TOTAL General Services**	295,295	142,246	128,903	566,444		566,444	(3,597)	562,847			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,017,690	61,573	5,808	1,085,071		1,085,071	(10,279)	1,074,792			10
10a	Therapy		463	101,702	102,165		102,165		102,165			10a
11	Activities	54,735	25		54,760		54,760		54,760			11
12	Social Services	24,924	129	1,049	26,102		26,102		26,102			12
13	Nurse Aide Training			968	968		968		968			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,097,349	62,190	114,327	1,273,866		1,273,866	(10,279)	1,263,587			16
	C. General Administration											
17	Administrative	58,401			58,401		58,401		58,401			17
18	Directors Fees											18
19	Professional Services			14,610	14,610		14,610		14,610			19
20	Dues, Fees, Subscriptions & Promotions			25,138	25,138		25,138	(12,573)	12,565			20
21	Clerical & General Office Expenses	81,141	6,263	39,058	126,462		126,462	(12,554)	113,908			21
22	Employee Benefits & Payroll Taxes			222,917	222,917		222,917		222,917			22
23	Inservice Training & Education			5	5		5		5			23
24	Travel and Seminar			2,560	2,560		2,560	(264)	2,296			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			73,192	73,192		73,192		73,192			26
27	Other (specify):*											27
28	**TOTAL General Administration**	139,542	6,263	377,480	523,285		523,285	(25,391)	497,894			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,532,186	210,699	620,710	2,363,595		2,363,595	(39,267)	2,324,328			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Hitz Memorial Home #0032979 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			171,722	171,722		171,722	(116,034)	55,688			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			129,689	129,689		129,689	(95,352)	34,337			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			301,411	301,411		301,411	(211,386)	90,025			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		21,987		21,987		21,987		21,987			39
40	Barber and Beauty Shops		62	11,158	11,220		11,220		11,220			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,784	36,784		36,784		36,784			42
43	Other (specify):*	153,601	20,598	108,883	283,082		283,082	(283,082)				43
44	**TOTAL Special Cost Centers**	153,601	42,647	156,825	353,073		353,073	(283,082)	69,991			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,685,787	253,346	1,078,946	3,018,079		3,018,079	(533,735)	2,484,344			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(162)	1		4
5	Telephone, TV & Radio in Resident Rooms	(3,435)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(15,894)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(264)	24		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,554)	21		24
25	Fund Raising, Advertising and Promotional	(11,414)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,159)	20		28
29	Other-Attach Schedule see attached schedule	(488,853)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (533,735)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (533,735)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Hitz Memorial Home

ID# 0032979

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Assisted Living Salary Expenses:	$		1
2	Dietary	(28,644)	43	2
3	House Daughters	(74,244)	43	3
4	Social Services	(9,188)	43	4
5	Supervisor	(23,823)	43	5
6	LPN	(17,702)	43	6
7				7
8	Assisted Living Supplies Expense:			8
9	Food and Supplies	(17,709)	43	9
10	General	(582)	43	10
11	Laundry Supplies	(338)	43	11
12	Maintenance Supplies	(1,205)	43	12
13	Housekeeping Supplies	(763)	43	13
14				14
15	Assisted Living Other Expenses:			15
16	Telephone and Cable TV	(1,675)	43	16
17	Employee Benefits and Payroll Taxes	(21,863)	43	17
18	Insurance	(41,596)	43	18
19	Professional Fees	(4,744)	43	19
20	Administrative	(9,564)	43	20
21				21
22	Assisted Living And Rental Other Expenses:			22
23	Repairs and Maintenance	(3,275)	43	23
24	Utilities	(24,903)	43	24
25	Security Services	(1,264)	43	25
26				26
27				27
28	Assisted Living Mortgage Interest	(79,458)	32	28
29	Non-Care Asset Depreciation	(116,034)	30	29
30				30
31	Resident Personal Purchases	-10279	10	31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(488,853)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(162)	0	0	0	0	0	0	0	0	0	0	(162)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,435)	0	0	0	0	0	0	0	0	0	0	(3,435)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,597)	0	0	0	0	0	0	0	0	0	0	(3,597)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(10,279)	0	0	0	0	0	0	0	0	0	0	(10,279)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(10,279)	0	0	0	0	0	0	0	0	0	0	(10,279)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(12,573)	0	0	0	0	0	0	0	0	0	0	(12,573)	20
21	Clerical & General Office Expenses	(12,554)	0	0	0	0	0	0	0	0	0	0	(12,554)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(264)	0	0	0	0	0	0	0	0	0	0	(264)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(25,391)	0	0	0	0	0	0	0	0	0	0	(25,391)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,267)	0	0	0	0	0	0	0	0	0	0	(39,267)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hitz Memorial Home # 0032979 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(116,034)	0	0	0	0	0	0	0	0	0	0	(116,034)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(95,352)	0	0	0	0	0	0	0	0	0	0	(95,352)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(211,386)	0	0	0	0	0	0	0	0	0	0	(211,386)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(283,082)	0	0	0	0	0	0	0	0	0	0	(283,082)	43
44	**TOTAL Special Cost Centers**	(283,082)	0	0	0	0	0	0	0	0	0	0	(283,082)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(533,735)	0	0	0	0	0	0	0	0	0	0	(533,735)	45

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Illinois South Conference of the United Church of Christ	100%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of Edwardsville						$	$			$	1
2	1999 Bond Issue		X	Nursing Facility Mortgage, 36.93%		03/01/99	1,006,182	686,242	03/01/14	6.3500	46,526	2
3	1999 Bond Issue Cost		X	Issue Cost Amortization		03/01/99	29,198	18,823			1,945	3
4												4
5												5
	Working Capital											
6	Bank of Edwardsville		X	Line of Credit		07/31/03		100,000	07/31/04	5.5000	1,760	6
7												7
8												8
9	TOTAL Facility Related						$ 1,035,380	$ 805,065			$ 50,231	9
	B. Non-Facility Related*											
10												10
11	Bank of Edwardsville											11
12	1999 Bond Issue		X	Assisted Living Mortgage, 63.07%		03/01/99	1,718,571	1,171,981	03/01/14	6.3500	79,458	12
13												13
14	TOTAL Non-Facility Related						$ 1,718,571	$ 1,171,981			$ 79,458	14
15	TOTALS (line 9+line14)						$ 2,753,951	$ 1,977,046			$ 129,689	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hitz Memorial Home COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0032979

CONTACT PERSON REGARDING THIS REPORT Marcia Haslett

TELEPHONE (618) 488-2355 FAX #: (618) 488-2361

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		Not-For-Profit organization, exempt	$	$
2.		from real estate taxes	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,077 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Assisted Living Facility, 12944 sq. ft., 26 units
Child Care Center (Rental Space), 5,726 sq. ft.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1976	$ 45,384	1
2					2
3	TOTALS			$ 45,384	3

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	33			1970	$ 176,881	$ 4,422	40	$ 4,422	$	$ 149,612	4
5	34			1975	418,286	10,457	40	10,457		302,386	5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements			1971	19,945	499	40	499		16,496	9
10	Improvements			1972	90		10			90	10
11	Improvements			1974	23,177	579	40	579		17,238	11
12	Improvements			1976	81,417	2,035	40	2,035		57,162	12
13	Improvements			1977	6,650	166	40	166		4,558	13
14	Improvements			1979	3,000	75	40	75		1,881	14
15	Improvements and Garage			1980	15,638	391	40	391		9,415	15
16	Improvements			1982	2,416	60	40	60		1,334	16
17	Roof and Improvements			1983	138,325	3,458	40	3,458		72,909	17
18	Roof and Improvements			1984	143,005	3,575	40	3,575		72,098	18
19	Dining Room			1985	28,447	711	40	711		13,749	19
20	Architecture Fees/Roof Repair			1987	12,112	303	40	303		5,173	20
21	Architecture Fees/Improvements			1988	8,001	200	40	200		3,217	21
22	Solarium and Architecture Fees			1989	67,025	1,676	40	1,676		25,274	22
23	Remodeling & New Garage			1990	29,672	916	40	916		12,826	23
24	Remodeling/Furnace/Control Temps/Architect Fees			1993	36,433	497	40	497		22,257	24
25	Sprinkler System/Water Heaters			1994	11,606	802	40	802		8,008	25
26	Roof Repair			1997	22,000	550	40	550		3,850	26
27	Air Conditioner			1998	5,439	136	40	136		827	27
28	Tank Replacement			1998	14,313	716	20	716		3,757	28
29	Air Conditioner			1999	3,280	164	20	164		847	29
30	Door Alarm			2000	1,164	116	10	116		553	30
31	Door Alarm			2000	1,563	156	10	156		612	31
32	Water Heater			2000	4,044	270	15	270		1,033	32
33	Kitchen Sewer Line			2000	2,721	181	15	181		680	33
34	Kitchen Fire Suppression System			2002	8,822	588	15	588		1,029	34
35	Door - Oxygen Room			2002	791	79	10	79		132	35
36	Garage Door & Sign			2003	2,171	145	10	145		145	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fire Protection/Water Heaters	2004	$ 9,344	$ 311	15	$ 311	$	$ 311	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,297,778	$ 34,234		$ 34,234	$	$ 809,459	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 448,183	$ 13,341	$ 13,341	$	10	$ 404,920	71
72	Current Year Purchases	8,752	708	708		10	708	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 456,935	$ 14,049	$ 14,049	$		$ 405,628	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transporation	Van Lift for 2000 Dodge	2000	$ 5,687	$ 1,137	$ 1,137	$	5	$ 4,550	76
77	Resident Transporation	Dodge Ram Wagon, 2000	2000	26,173	5,235	5,235		5	21,811	77
78	Resident Transporation	Dodge Top,Rear Door Additions	2003	6,884	1,033	1,033		5	1,033	78
79										79
80	TOTALS			$ 38,744	$ 7,405	$ 7,405	$		$ 27,394	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,838,841	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 55,688	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 55,688	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,242,481	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	AL & CC Bldg & Improvements	$ 3,926,533	$ 98,826	$ 1,110,591	86
87	AL & CC Equipment	318,030	17,207	315,364	87
88					88
89	Vehicles	27,065		27,065	89
90	Land-Asst. Living & Child Care	25,000			90
91	TOTALS	$ 4,296,628	$ 116,033	$ 1,453,020	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. ____
This amount was calculated by dividing the total amount to be amortized ____
by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 968	$	$ 968
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 968	$	$ 968
10	SUM OF line 9, col. 1 and 2	(e)	$ 968			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	N/A	$ 33,811	$		$ 33,811	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		N/A	26,529			26,529	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		N/A	41,362			41,362	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				21,987		21,987	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 101,702	$ 21,987		$ 123,689	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Hitz Memorial Home # 0032979 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 329,885	$	1
2	Cash-Patient Deposits	2,417		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 32,000)	274,926		3
4	Supply Inventory (priced at)	15,928		4
5	Short-Term Investments			5
6	Prepaid Insurance	162,871		6
7	Other Prepaid Expenses	3,897		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 789,924	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	70,384		13
14	Buildings, at Historical Cost	595,167		14
15	Leasehold Improvements, at Historical Cost	4,629,143		15
16	Equipment, at Historical Cost	840,774		16
17	Accumulated Depreciation (book methods)	(2,695,504)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	29,198		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(10,375)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,458,787	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,248,711	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 256,212	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,417		28
29	Short-Term Notes Payable	100,000		29
30	Accrued Salaries Payable	136,422		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,607		35
	Other Current Liabilities(specify):			
36	Bonds Payable	173,157		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 671,815	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,685,066		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,685,066	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,356,881	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,891,830	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,248,711	$	48

***(See instructions.)**

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,145,623	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,145,623	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(253,793)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (253,793)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,891,830	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,811,636	1
2	Discounts and Allowances for all Levels	(280,085)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,531,551	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	18,567	5
6	Therapy	125,979	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 144,546	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	10,991	13
14	Non-Patient Meals	162	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	8,438	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	12,554	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 32,145	23
	D. Non-Operating Revenue		
24	Contributions	38,052	24
25	Interest and Other Investment Income***	15,894	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 53,946	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	2,206	28
28a	Loss on Sale of Assets	(108)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,098	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,764,286	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	566,444	31
32	Health Care	1,273,866	32
33	General Administration	523,285	33
	B. Capital Expense		
34	Ownership	301,411	34
	C. Ancillary Expense		
35	Special Cost Centers	316,289	35
36	Provider Participation Fee	36,784	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,018,079	40
41	**Income before Income Taxes (line 30 minus line 40)****	(253,793)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (253,793)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,692	2,044	$ 45,184	$ 22.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,186	8,574	157,203	18.33	3
4	Licensed Practical Nurses	13,316	14,297	225,420	15.77	4
5	Nurse Aides & Orderlies	47,311	51,339	570,004	11.10	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,428	2,080	29,804	14.33	9
10	Activity Assistants	3,575	3,771	24,931	6.61	10
11	Social Service Workers	1,795	2,387	24,924	10.44	11
12	Dietician					12
13	Food Service Supervisor	1,668	2,080	26,921	12.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,731	14,058	112,116	7.98	15
16	Dishwashers					16
17	Maintenance Workers	3,611	4,180	64,371	15.40	17
18	Housekeepers	4,840	5,039	50,225	9.97	18
19	Laundry	5,737	6,463	41,662	6.45	19
20	Administrator	1,856	2,080	58,401	28.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,584	5,252	81,141	15.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,849	2,100	19,879	9.47	31
32	Other Health Care(specify)					32
33	Other(specify) Assisted Living	15,990	17,158	153,601	8.95	33
34	TOTAL (lines 1 - 33)	130,169	142,902	$ 1,685,787 *	$ 11.80	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	124	$ 4,349	1-3	35
36	Medical Director	$400/mo.	4,800	9-3	36
37	Medical Records Consultant	15	699	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	900	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	18	1,049	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	193	$ 11,797		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marcia Haslett	Administrator	0.00%	$ 58,401
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,401

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Scheffel & Company, P.C.	Accounting	$ 14,610
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 14,610

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,792
Unemployment Compensation Insurance	5,381
FICA Taxes	114,772
Employee Health Insurance	29,608
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan Contribution	21,246
Other Employee Benefits	10,118
TOTAL (agree to Schedule V, line 22, col.8)	$ 222,917

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,447
Health Care Worker Background Check	
(Indicate # of checks performed 66)	808
Dues & Subscriptions	4,310
Promotional & Public Relations	11,414
Yellow Pages	1,159
Less: Public Relations Expense	(11,414)
Non-allowable advertising	( )
Yellow page advertising	(1,159)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,565

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,560
Non-care Related Fees	(264)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,296

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Hitz Memorial Home **#** 0032979 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN $3,353, INHAA $100**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10-15 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,992** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **36,784**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **162**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Scheffel & Company, P.C.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not yet completed**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.